

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-010552

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 128Primary Registration District No. 200Registrar's No. 555

FILED APR 9 1962

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		c. CITY OR TOWN <b>Springfield</b>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Burge Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>RFD#11 Box 1415</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>OLLIE MAE PETERS</b>			4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1962</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>17 Jan. 1908</b>	9. AGE (last birthday) <b>59</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	11. BIRTHPLACE (City and state or country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	

13a. FATHER'S NAME <b>Davis</b>	13b. MOTHER'S MAIDEN NAME <b>Isenberg</b>	14. NAME OF HUSBAND OR WIFE <b>Louis E. Peters</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT <b>Louis E. Peters (Husband) Springfield, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from <b>3-31-62</b> to <b>4/5/62</b> and last saw her alive on <b>4/5/62</b> Death occurred at <b>9:15</b> A.m. on the date stated above, and to the best of my knowledge, from the causes stated.
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22. SIGNATURE <b>Carle H. Schaffner</b> (Degree or title)	22b. ADDRESS <b>1630 N. Jefferson Springfield, Missouri</b>	22c. DATE SIGNED <b>4-6-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/7/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>
23d. LOCATION (City, town, or county) <b>Springfield, Missouri</b>		(State)

24. FUNERAL DIRECTOR <b>KLINGNER MORTUARY, INC. Springfield, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>4-6-62</b>	26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>
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jhc

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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Rev. 4/5903970397

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# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*John Klumpp Jr*

Licensed Embalmer No. 5102

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Permit issued 4-6-65